STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155265	A. BUILDING 00 B. WING	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD	101 POTTERS LANE CLARKSVILLE, IN47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure survey. Survey Dates: August 22, 23, 24, 25, 2011 Facility number: 000166 Provider number: 155265 AIM number: 100267080 Survey team: Donna Groan, RN, TC Gloria Reisert, MSW (August 23, 24, 25, 2011) Avona Connell, RN Dorothy Navetta, RN Census bed type: SNF: 8 SNF/NF: 103 Total: 111 Census payor type: Medicare: 21 Medicaid: 72 Other: 18 Total: 111 Sample: 23 Supplemental sample: 12 These deficiencies also reflect state	F0000	Please accept this Plan of Correction as the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	findings cited in accordance with 410 IAC 16.2. Quality review completed on August 29, 2011 by Bev Faulkner, RN			

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F0225 SS=D	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure an allegation of a missing ring was reported immediately to state officials for 1 of 1 resident reviewed related to an allegation of a	F0225	F225 – The lost ring was reported to Indiana State Department of Health on 8/23/11. The final	09/22/2011

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	misappropriation of missing property (a ring) in a sample of 23. (Resident #34) Findings include: On 8/23/11 at 2 p.m., in interview with the Administrator related to allegations of abuse, neglect and or missing items, the Administrator indicated Resident #34 had reported his ring was missing on 8/21/11. The Administrator indicated the state agency had not been notified. The Administrator provided a Communication/Response Form, dated 8/21/11, which included, but was not limited to: "Resident [named] Issue(s): Missing milatary [sic] class ring. Missing 8/20/11. Department Response: Room search completed ring not found - resident stated to SS (Social Services) that he takes off q. (every) night and lays on table. SS searched drawers best they could with his permission; however resident has a lot of stuff in his drawers - Soc. Services to assist with cleaning and organization of drawers." 3.1-28(d)		report was completed and faxed on 8/24/11 to Indiana State Department of Health. All residents that report lost items have the potential to be affected. Administrator has reviewed policy and procedure and Indiana State Department of Health reporting guidelines and will report lost items as required. All staff has been educated to contact administrator immediately on any lost item and in addition write concerns down on Communication Response Form. All reports of lost or missing articles reported will be reviewed in morning meeting Monday through Friday with all disciplines attending. All missing items reports will be discussed monthly in PI meeting to ensure no patterns have been identified. Date of Completion 9/22 /11.	
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.			

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	Based on record review and interview, the facility failed to implement the policy and procedure for an allegation of misappropriation of resident property for 1 of 1 resident reviewed related to an allegation of a missing ring in a sample of 23. (Resident #34) Findings include: On 8/23/11 at 2 p.m., in interview with the Administrator related to allegations of abuse, neglect and or missing items, the Administrator indicated Resident #34 had reported his ring was missing on 8/21/11. The Administrator indicated the state agency had not been notified. The Administrator provided a Communication/Response Form, dated 8/21/11, which included, but was not limited to: "Resident [named] Issue(s): Missing milatary [sic] class ring. Missing 8/20/11. Department Response: Room search completed ring not found - resident stated to SS (Social Services) that he takes off q. (every) night and lays on table. SS searched drawers best they could with his permission however resident has a lot of stuff in his drawers - Soc. Services to assist with cleaning and organization of drawers." On 8/22/11 at 11 a.m., the Administrator provided the Abuse policy revised	F0226	F226 – The lost ring was reported to Indiana State Department of Health on 8/23/11. The final report was completed and faxed on 8/24/11 to Indiana State Department of Health. All residents that report lost items have the potential to be affected. Administrator has reviewed policy and procedure and Indiana State Department of Health reporting guidelines and will report lost items as required. All staff has been educated to contact administrator immediately on any lost item and in addition write concerns down on Communication Response Form. All reports of lost or missing articles reported will be reviewed in morning meeting Monday through Friday with all disciplines attending. All missing items reports will be discussed monthly in PI meeting to ensure no patterns have been identified. Date of Completion 9/22 /11.	09/22/2011

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	10/31/09, which included, but was not limited to: "Compliance Guidelines #14. "Results of an alleged abuse investigation are reported to the Executive Director (Administrator) or their designee and to other officials in accordance with state law within five working days of the incident or in accordance with State law...." 3.1-28(a)			

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F0272 SS=A	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. 3. The clinical record for Resident #51 was reviewed on 8/23/11 at 2:20 p.m. The resident's diagnoses included, but were not limited to hypertension, depression and schizophrenia. The annual MDS, dated 11/1/10, Section H Bladder and Bowel indicated resident was always continent. Section V Care Area Assessment (CAA) Summary indicated	F0272	F 2721. Resident #79 had a 14 day MDS on 06/23/2011, a 30 day MDS on 07/15/2011 and a EOT MDS on 07/17/2011, all were coded accurately for this resident receiving dialysis.Resident # 11 had A MDS with significant correction submitted to the state on 09/07/2011 to include the diagnosis of Cerebral Palsy.Resident #51 had a quarterly MDS on 07/20/2011, a	09/22/2011

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	Care Area triggered 06 Urinary incontinence. The information on area 06 included, but was not limited to: 6. Urinary incontinence and indwelling catheter... "Res (resident) Incont. (incontinent). B & B (bowel and bladder)." The CNA (certified nursing assistant) assignment sheet provided on entrance 8/22/11 at 9 a.m., included, but was not limited to: "Elimination Incont." On 8/23/11 at 8 a.m., in interview with the MDS Coordinator, she indicated the information was coded wrong. The resident had always been incontinent. 3.1-31(c)(1) 3.1-31(c)(3) Based on record review and interview, the facility failed to accurately assess and document the residents incontinence status and diagnosis in the Minimum Data Set (MDS) assessment. This affected 3 of 23 sampled residents whose MDS's were reviewed. (Resident # 11, # 79, # 51) Findings include:		quarterly MDS on 04/06/2011 and a quarterly MDS on 06/22/2011, all were coded accurately for this resident as incontinent. 2. The Interdisciplinary Team will review the most current MDS for each resident to assess the accuracy of diagnoses for residents, for those receiving dialysis, and correct any information deemed to be inaccurate. 3. The DDCM will inservice the MDS coordinators on the accuracy of information coded on the MDS. The Case Manager will verify the accuracy of the coded information on each MDS prior to affixing their signatures.4. The Case Manager/designee will monitor through observation and record review the accuracy of the MDS. The data will be reviewed and analyzed monthly for three months or until 100% compliance is achieved as determined in the monthly PI meeting. 5. 09/22/11.	

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	1. On 8/24/2011 at 10:00 a.m., review of clinical record of Resident # 79 indicated, but was not limited to; diagnoses of chronic obstructive pulmonary disease, end-stage renal failure with hemodialysis, (ESRF), and diabetes mellitus. A physician's order, dated 6/14/2011 at 5:00 p.m., indicated dialysis at [named] dialysis center Tuesdays, Thursdays, and Saturdays at 11:45 a.m. The MDS, dated 6/20/2011, under Section 0, J was not checked under the special treatments, procedures, and program that dialysis was now being performed. On 8/25/2011 at 9:30 a.m., in an interview with MDS Coordinator # 1, she indicated the MDS, dated 6/20/2011, was the first one done after the resident came back from the hospital with dialysis orders and "it was missed." 2. On 8/24/2011 at 11:50 a.m., review of the clinical record for Resident # 11 included diagnoses of mental retardation, seizure disorder and cerebral palsy. According to an INDIVIDUAL HABILITATION PLAN, dated 12/7/2005, indicated the residents diagnoses included "Cerebral Palsy."			

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	The interdisciplinary care plan, dated 7/25/2011, in regards to her nutrient needs included, but was not limited to; "Decreased ability to consume sufficient energy R/T [related to] cerebral palsy" The MDS, dated 7/28/2011, under Section I4400 was coded (0) indicating that Resident # 11 did not have a diagnosis of cerebral palsy. On 8/25/2011 at 9:30 a.m., in interview with MDS Coordinator # 1, she indicated the diagnosis of cerebral palsy was never put on the diagnosis list and therefore, it was missed.			
F0333 SS=D	The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure Renagel (a phosphorus supplement) was administered when the resident received HS (night time) snacks for 1 of 4 dialysis residents reviewed for medication administration within the sample of 23. (Resident #8) Findings include: The clinical record for Resident #8 was reviewed on 8/23/11 at 11:05 a.m. The resident's diagnoses included, but were	F0333	F333 – On 8/24/11 the physician and family were notified of medication variance. A clarification of physician order for administration of Renagel was also obtained on 8/24/11. All residents on Renagel have the potential to be affected. There was no other resident identified to be receiving this medication. Inservice with all licensed nurses in regards to care of the hemodialysis patient will be completed by 09/22/11. Daily monitoring will be completed on flow records and medication	09/22/2011

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	not limited to renal failure requiring dialysis and diabetes mellitus. An Orders/Progress Notes, signed and dated 3/18/11, by the nurse practitioner, indicated "Increase Renagel (to maintain phosphorus levels) 2 tabs with meals and 1 tab with snacks (underlined 1 tab with snacks)." Review of the August 2011 Medication Administration Record (MAR) included, but was not limited to: "Renagel (Sevelamer) - Do not crush 800 mg (milligram) po (by mouth) prn (as needed) with snacks." Review of the Physician Telephone Orders, dated 3/19/11 9:30, included, but was not limited to: "Renagel 800 mg tab po PRN with snacks" There was no documentation the Renagel had been administered when the resident consumed a bedtime (HS) snack or with any other snacks documented during the day. The 2011 Nutrition Flow Sheet Records reviewed, at this time, indicated the following: Snacks Accepted: March 19 - 31; April 1 - 28, 30; May 1 - 31; June 1 - 29; July 1 - 18, 23 - 31; August record not filled in thru 24. There was no evidence on the MAR the resident received the Renagel on the dates a snack was consumed.		records by DNS/designee until 30 days of compliance is achieved. Then weekly thereafter as an ongoing practice. Date of completion 9 / 22 /11.	

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	On 8/24/11 at 1:25 p.m., in interview with the Director of Nursing she indicated "OK, we'll get right on it." when she learned of the error. The order received was for Renagel "1 tab with snacks" while the transcription to the telephone order form indicated "PRN with snacks". 3.1-25(b)(9) 3.1-48(c)(2)			
F0363 SS=E	Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, interview and record review, the facility failed to ensure recipes were available for the pureed entree for 1 of 1 pureed foods observed being prepared. This deficient practice had the potential to affect 3 of 23 sampled residents (#111, 109, 83) and 12 residents in a supplemental sample of 12. (Resident #81, 84, 18, 27, 15, 5, 48, 35, 10, 68, 53, 32) Findings include: On 08/24/11 at 10:03 a.m., Cook #1, indicated she was planning to puree 20 servings of the menued beef, onions and	F0363	F363 – Resident # 81,84,18,27,15,5,48,35,10,68,53,32,111,109 and 83 received an alternate menu which had recipe available for cooks. All residents receiving a pureed diet were affected by receiving an alternate menu on 8/24/11. Nutritional Services Manager will review pureed diet menu weekly to ensure all recipes are available for cooks use one week in advance.	09/22/2011

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	peppers. She indicated she had 15 residents she purees for and to allow for a second helping prepares for 20. She was unable to locate a recipe for the pureed beef, onions and peppers. At this time, three books containing recipes were reviewed and the recipe was not found. The Dietary Manager, at this time, indicated "When a recipe could not be found she would print it as she had the recipes on her computer." She was unable to locate the pureed recipe on the computer and indicated she "would contact corporate to send the recipe." At 11:01 a.m., the Dietary Manager indicated she was still waiting for corporate to send the recipe. In interview with Cook #1, at this same time, she indicated she usually makes sure all recipes are available prior to starting the meal for the day. She indicated she" failed to ensure all recipes were available for the noon meal today." At 11:42 a.m., a substitute for the pureed beef, onions, and peppers was prepared and placed on the steam table at 12:03 p.m. On 08/25/11 at 7:00 a.m., upon entrance to the facility, a copy of the pureed recipe		Weekly pureed diet menus will be initialed by Nutritional Services Manager as reviewed and copies of menus will be provided to Executive Director with results reported monthly to PI committee. This will be an ongoing practice. Date of completion 9/22 /11.	

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	for the beef/w peepers & onions was provided with a note attached which indicated the recipe was received at 4:00 p.m. on 08/24/11. The noon meal service started at 11:30 a.m. At this time, the Dietary Manager provided a list of residents requiring a pureed diet which included (Resident #81, 84, 18, 27, 15, 5, 48, 35, 10, 68, 53, 32, 111, 109, and 83). 3.1-21(a)(1) 3.1-21(a)(3)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interview, the facility failed to ensure equipment was clean and in good repair for 2 of 2 dietary observations. This deficient practice had the potential to affect 106 of 106 residents who received meals from the kitchen. Findings include: On 08/22/11, between the hours of 9:00 a.m. and 9:13 a.m., the following was observed: 1. The can opener blade was soiled with a dried black substance.	F0371	F371 – No particular resident was identified. All residents have the potential to be affected. The can opener, mixer blades and burner were immediately cleaned. The bowls of Cream of Wheat was discarded. The steamer cart's bottom shelf was immediately cleaned. The gasket was cleaned immediately and then replaced on 8/25/11. Nutritional Services Manager	09/22/2011

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	2. The wire mixer blade on the Univex mixer, stored as clean, was soiled with a dried cream colored substance. 3. Four bowls of cream of wheat were on a shelf on the back of the stove. The bowls were soiled on the outer surfaces with the cream of wheat. Dietary Staff #1, indicated "The bowls were for a resident who received cream of wheat for all three meals." 4. One of 6 burners on the stove was soiled with a heavy crusty substance. 5. The deep fryer was soiled on the inner surfaces and on top of the grease was food debris/crumbs. The Dietary Manager indicated the fryer was cleaned weekly. Review of the cleaning schedule, provided on 08/25/11 at 8:25 a.m., indicated the fryer was cleaned weekly on Tuesday and was last cleaned on 08/16/11. 6. The steamer was sitting on a cart which was soiled with grease and food particles on the bottom shelf. 7. The gasket on the bottom of right door of the reach-in double door refrigerator was torn loose approximately 18-20 inches and soiled with a sticky red and		will provide inservice to all staff on appropriate cleaning protocols 9/14/11. Nutritional Services Manager to conduct daily rounds to ensure sanitation of items is maintained. Results of daily checks will be provided to administrator. Administrator will conduct weekly checks to ensure compliance and results will be reported to PI committee monthly. This will be an ongoing practice. Date of completion 09/22/2011.	

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	155265	A. BUILDING 00 B. WING	08/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD	101 POTTERS LANE CLARKSVILLE, IN47129

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	yellow substance. The gasket on the bottom of the left door was soiled with a sticky- reddish colored substance. 3.1-21(i)(3)			
F0469 SS=F	The facility must maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, record review, and interview, the facility failed to ensure the facility was free of flies. This deficient practice was actually observed to affect Resident # 29 and had the potential to affect all 111 current residents. Findings include: On 8/23/11 between 4:30 p.m. and 4:55 p.m., LPN #1 was observed giving an intravenous pain medication to Resident #29. The resident was lying in bed. There were three flies flying and landing on the resident's left arm and abdominal area. When queried, the resident indicated "The flies bug me to death." LPN #1 asked Resident #29 if she could	F0469	F469 – Room of resident 29 was relieved of flies on 8/25/11. All residents have the potential to be affected. Air curtains will be installed on resident patio door to assist in prevention of flies entering the facility and continue to allow residents to enter and exit independently with automatic opener. Maintenance Director/Designee will conduct daily rounds Monday through Friday to ensure facility remains free from flies	09/22/2011

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	turn on the air conditioner to help with the flies. The resident indicated "Yes." On 8/22/11 at 11 a.m., the clinical record for Resident #29 was reviewed. The resident's diagnoses included, but were not limited to lower extremity contractures. Resident was dependent for care. On 8/24/11 between 10:03 a.m. and 12 p.m., during the kitchen observation, flies had to be continuously swatted away as the cook was preparing pureed foods. On 8/24/11 between 2:15 p.m. and 3 p.m., while walking down the 200 Hall, a dirty linen/clothes hamper was observed between Rooms 210 and 208. There were six flies flying around and landing on the hamper. After entering Resident #29's room, three flies were observed on the resident's gown. There was a fly swatter lying on an oversized chair for the resident in the first bed. On 8/24/11 at 2:10 p.m., in interview with CNA #2, she indicated the flies come in from the patio every day, as residents go out to smoke and the door remains open for a set time period. On walking into the sitting area, which leads to the patio, a resident had just gone out to smoke and the door was open. On the wall to the left		until the season ends. Results of checks will be reported to Administrator and discussed during facilities monthly PI meeting. All staff has been informed to report all issues with pests immediately to Executive Director. Date of completion 09/ 22 / 11.	

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	of the door was an insect light, which was not on. Once the table was moved to see if the light was plugged in, the light came on. In interview with the Administrator, at 2:30 p.m., she indicated "air curtains were being ordered to prevent flies from entering the building to maintain comfortable pest free environment." At 3 p.m., the Administrator provided a Capital Budget Request form requesting two air curtains. On 8/25/11 at 2:40 p.m., the Administrator provided the Pest Control policy, revised 10/31/08, which included, but was not limited to: "Rationale routine inspections are conducted periodically at each Center for evidence of pests, insect or pest sightings are reported to the housekeeping/maintenance supervisor." On 8/25/11 at 2:45 p.m., the Maintenance Supervisor provided an invoice for routine pest control. The last visit was 8/18/11, which indicated "No interior complaints and the kitchen was treated for fungus gnats." 3.1-19(f)(4)			

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F0499 SS=A	The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. Professional staff must be licensed, certified, or registered in accordance with applicable State laws. Based on record review and interview, the facility failed to ensure professional licenses/certifications were current for 1 of 1 Beautician in a sample of 106 professional licenses/certifications. (Beautician #1) Finding includes:. Review of the professional licenses/certifications books on 8/25/2011 at 1:15 p.m., the beautician's license was noted to have expired on 8/1/2011. Upon checking the state licensure board registry on the computer at 2:40 p.m., the Administrator indicated she had learned the beautician had let her license lapse and had just applied this day to have it renewed. She also indicated the beautician worked on Tuesdays and Wednesdays and had worked on 8/2, 8/3, 8/9, 8/10, 8/16, 8/17, 8/23 and 8/24. 3.1-14(s)	F0499	1. No specific resident identified.2. All residents recieving beautician services have the potential to be affected. Beautician was immediately contacted regarding her expired license and informed not to come back in license was expired... contract was terminated 3. Once hired the beautician license will be verified and copied prior to start date by administrator. 4. Staff Development Coordinator will implement a system for tracking license renewal due dates for the beautician. 5. 09/22/11.	09/22/2011

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review, observation and interview, the facility failed to ensure documentation was accurate for post dialysis assessment and complete and accurate diagnosis for 2 of 23 residents reviewed. (Resident # 79, # 11) Findings include: 1. On 8/24/2011 at 10:00 a.m., record review of Resident # 79 indicated diagnoses including, but was not limited to; end-stage renal failure with hemodialysis [recirculating blood to remove impurities] and diabetes mellitus. The POST-DIALYSIS LOG indicated under the access site "Bruit or thrill present (+/-) if applicable." Eighteen out of 18 times it was charted as "+". The Dialysis/Renal Failure Interdisciplinary Care Plan indicated "NOTE: No thrill/bruit present with	F0514	F514 – Resident # 79 requires no corrective action as care plan accurately identifies needs and treatment plan. Resident # 11 had diagnosis of cerebral palsy added by physician on 9/7/11. All residents with a Tessio Catheter have the potential to be affected. Currently, one other resident identified with this type of catheter. Treatment plan and flow sheet audited on 8/25/11 without discrepancies. Inservice completed with all licensed nurses on the care of the hemodialysis resident by 09/22/11. Director of Nursing Services/Designee will monitor dialysis flow sheets daily Monday through Friday until 30 days of compliance	09/22/2011

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	Tessio [central catheter used for hemodialysis] or CV [central vascular] Dialysis Catheters." On 8/24/2011 at 2:35 p.m., upon observation of Resident # 79, it was noted the resident had a Shiley (central catheter used for hemodialysis) in her right subclavian (front chest). On 8/25/2011 at 1:00 p.m., in interview with the Assistant Director of Nursing (ADON), she indicated she "could see it was charted wrong based on what she knew about the resident." The ADON indicated the nurses had been inserviced on the difference between Shiley and shunts [combining of vein and artery, placed under the skin, usually in arm] upon hire. On 8/25/2011 at 1:05 p.m., in interview with the Director of Nursing (DON), she indicated the documentation concerns were with some of the newer nurses related to the Shiley versus shunt. 2. On 8/24/2011 at 11:50 a.m., the clinical record for Resident # 11 was reviewed. The resident's diagnoses included, but were not limited to: mental retardation, seizure disorder, cerebral palsy.		achieved then weekly thereafter as ongoing practice. Date of completion 9/22 /11.	

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	The CASE ANALYSIS, dated 1/31/2001, included but was not limited to: HEALTH/MEDICAL INFORMATION: ..."decline in functioning, as her cerebral palsy"... The INDIVIDUAL HABILITATION PLAN, dated 12/7/2011, included, but was not limited to: . ..."diagnoses in the [name of facility] medical chart include Cerebral Palsy"... Documentation was lacking the diagnosis of cerebral palsy was carried over into the monthly physician's orders under diagnoses. On 8/25/2011 at 9:30 a.m., in interview with Minimum Data Set (MDS) Coordinator # 1, she indicated that the diagnosis of cerebral palsy was never put on the diagnosis list. 3.1-50(a)(1) 3.1-50(a)(2)			

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F0518 SS=D	The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. Based on observation, record review and interview, the facility failed to ensure laundry personnel were trained on how to turn off the gas valve to the dryers in an emergency for 1 of 1 laundry employees observed. (Laundry Employee #1) Findings include: On 8/24/11 at 2:37 p.m., Laundry Employee #1 was observed folding clothes near the dryers. In interview at this time, the employee was queried if there were a fire in the dryer, what would you do? The employee indicated she would grab an extinguisher and call maintenance. She indicated the dryers were electrical. In interview with the Administrator at 3:25 p.m., she indicated the dryers ran on gas. At 3:35 p.m., Laundry Employee #1 was queried where would you turn off the gas to the dryers? She indicated she did not know. On 8/25/11 at 10 a.m., the Housekeeping Supervisor, indicated his staff receives training the first day. He indicated the Maintenance Director was to go over fire and safety with employees the first day.	F0518	F518 – No particular resident identified. All residents have the potential to be affected. Laundry Employee #1 was inserviced on Fire and Safety policies and procedures for facility which includes education on gas shut off locations. HSG Housekeeping Supervisor must present completed orientation checklist to Executive Director/Designee prior to working any new employee. HSG Housekeeping Manger to include names of new employees on checklist monthly written report to Executive Director. This will be an ongoing practice. 09/22/11	09/22/2011

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	Documentation was lacking Laundry Employee #1 had been trained. On 8/25/11 at 2 p.m., the personnel files were reviewed. Laundry Employee #1 was hired on 8/5/11. 3.1-51(b)			
F9999	STATE FINDING: 3.1-14 PERSONNEL Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (5) Professional licensure, certification, or registration number or dining assistant certificate or letter of completion if applicable. This State Rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure professional licenses/certifications were available in the employee files for 1 of 8 Occupational Therapists, 1 of 11 Physical Therapists, 1	F9999	F999 – State Finding No resident identified. All residents have potential to be affected. 100% audit was completed on 8/25/11 on all employees who have a professional license or certification. Staffing Development Coordinator will implement a consistent practice of printing and verification of all licenses prior to hire and track renewal times monthly. Director of Nursing Services will verify prior to orientation. This will be an ongoing practice. Date of completion 9/22 /11.	09/22/2011

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	of 48 Certified Nursing Assistants, and 1 of 1 Registered Dietitian licenses/certifications reviewed in a sample of 106 licenses/certifications. (OT #1, PT #1, RD #1, CNA #1) Findings included: Review of the employee licenses/certifications on 8/25/2011 at 1:15 p.m., indicated the following staff's professional licenses/certifications were not available. RN #1 indicated at this time, she would have to print them off from the computer for review as she did not have a copy of them: 1. Occupational Therapist #1 was hired on 12/22/1997. Documentation was lacking of a current license in his file. 2. Physical Therapist #1 was hired on 5/18/2010. Documentation was lacking of a current license in his file. 3. CNA #1 was hired into the nursing department on 3/2/2011. Documentation was lacking of a current certification in his file. 4. Registered Dietitian (RD) #1 was hired into the dietary department on 5/16/2011. Documentation was lacking of a current license in her file.			

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	3.1-14(q)(5)			